

Values, virtues and initiatives—time for a conversation

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INTRODUCTION

In the last 10 years or more, there has been a proliferation of “innovations” under the guise of improving patient safety and quality improvement. Service and quality improvements have a dominant focus on small-scale projects, incorporating locally collected “evidence” and engaging in small “tests of change” usually using PDSA (Plan, Do, Study, Act) cycles that get scaled up across organizations if considered to be successful. Whilst there is much to applaud many initiatives that have happened in improving safety in hospitals (in particular), the questions have to be asked—“how many PDSA cycles does it take to change a culture”? and “how many innovations are needed before practice can be considered safe”? Whilst the intuitive appeal of initiatives to help improve particular aspects of practice is very seductive, when will we realize that these innovations are addressing symptoms and not the cause(s) of an erosion of a healthcare system where person-centredness and compassion are on everyone's lips but the everyday reality is one of survival? A person-centred healthcare system has values and virtues at its core—values that focus on ensuring that all persons have their personhood respected and taken account of in service delivery models; and virtues that focus on enabling people to flourish in their roles, in order for them to be the best that they can be in any given situation (Buetow, 2016). In a person-centred healthcare system, all evidence matters and all evidence needs to play into decision-making. So, in that regard, the way “initiative-itis” has taken over nursing and health care is concerning at several levels, but of most concern to us is the erosion of individual personhood of nurses and a pretence that success in making these initiatives work somehow enhances staff flourishing. Take, for example, improving safety during drug-administration. Are tabards with “Do not disturb” front and back really the best way of improving safety during medication rounds? (is the problem not with the idea of “rounds” in the first place?). Whilst there is some (albeit limited) evidence that these tabards work in reducing drug errors (Scott, Williams, Ingram, & Mackenzie, 2010), the message they give to patients (“leave me alone”) is far from person-centred and the morally compromising situation in which it places nurses in terms of “caring values” is far from acceptable. So yes, whilst it may give nurses the space to just focus on administering the right drug to the right person at the right time, the consequences of this safety initiative are wide-ranging and of much greater impact.

In the same vein, the compromising of the virtue of “interdependence” can be seen in other initiatives such as “protected mealtimes”. How ridiculous is the exclusion of relatives from hospital wards during “protected” mealtimes? Surely, if we are committed to person-centred healthcare systems, then partnership in care needs to go beyond models of consultation and feedback and be genuinely focused on care partnership. It has long been recognized (Lennard-Jones, 1992) that when it comes to enhancing the nutritional status of patients (particularly older people), hospitals have little to be proud of despite a range of initiatives. We know that mealtimes are interrupted by, for

example, the consultant and team arriving for their ward round. Clearly, if patients are interrupted they may eat less and the problem of nutrition in hospital, especially of older people, is an identified problem (SCIE, 2009). However, the problem is not only the interruption, the problem is the nurses who should have the authority and the courage to tell the consultant to come back later, when the patient is not eating. In any case, how welcoming for any visitor—professional or relative—is a sign saying “This is a protected mealtime environment—NO ENTRY”? How much more welcoming would a sign saying “Mealtime in progress—come and join us” be? After all, relatives can play a major role in helping patients to eat and why should we not—after they have had appropriate training—invite the consultant and the entourage to help serve the food and sit with patients while they eat? Whilst protecting patients from continuous interruptions by professionals who are more focused on managing their own time than what works best for patients, a blanket ban on interruptions is surely misguided and morally compromising.

Add to these, the myriad “initiatives” over the years—in no special order—of evidence-based practice, competence-based education, leadership training, nursing models and high-fidelity simulation, we see an obsessive focus on symptoms and a significant neglect of finding a cause for the disease. Without doubt, each of these is dreamed up and implemented with the best of intentions. However, while the freight train of initiatives continually rumbles down the track, the juggernaut of evidence never arrives. Not that evidence is king in all that we do; the opening example of the tabard is a classic example of something that may well have been shown to work but at what cost? The dignity of the nurses, who are cutting themselves off from engagements that might be important, because something had to be done and an easy “solution” was implemented without thought to the consequences. A nurse in a tabard may well dispense medications more safely but take his or her reduced dignity into another situation where they care less about the outcome. After all, there is—as yet—no tabard that ensures a nurse delivers an act of loving kindness, an act of human caring or a sympathetic touch.

It would be petty of us to go through the list of every initiative that has been introduced into nursing and health care under the guise of making care safer and deal with each in turn from the perspective of person-centred values and virtues. Suffice to say, where many things seem like common sense—the evidence is not just lacking; it is contrary. For example, common sense dictates—as proposed in the Francis Report (2013) that a period working as a care assistant will make a person a better nurse. However, the first studies comparing nursing students with and without previous caring experience show that those with previous experience are either no better or score lower on emotional intelligence...not a very good sign (Snowden et al., 2015; Stenhouse et al., 2016). It also makes sense that university education for nurses is bound to make them less effective nurses since it detracts from the real job of caring for patients; but again, this is not supported by the evidence which consistently, and very recently, demonstrates the opposite (Gkantaros et al., 2016).

If our goal is to develop person-centred healthcare systems that are genuinely concerned with placing “the person” at the heart of decision-making, then we need to STOP and rethink our obsession with quick-fix solutions and instead consider how far we are willing to compromise the values and virtues that are core to nursing. We believe the time is right to initiate a moratorium on

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these “tests of change” and initiate a conversation at the highest level about nursing and what it wants to be.

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